Supreme Care UK Ltd

# Victoria House Care Home

## Inspection report

71-73 Victoria Road
Polegate
East Sussex
BN26 6BX
Tel: 01323 487178
Website: www.supremecareuk.com

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## Ratings

| Overall rating for this service | Inadequate |
|---|---|
| Is the service safe? | Inadequate |
| Is the service effective? | Inadequate |
| Is the service caring? | Inadequate |
| Is the service responsive? | Inadequate |
| Is the service well-led? | Inadequate |

## Overall summary

This inspection took place on 31 July and 7 & 14 August 2015 and was unannounced. Victoria House Care Home provides accommodation and personal care for up to 23 people who are older or who have dementia. Some people had health needs such as diabetes, and others needed support with their mobility. There were 16 people living at the home at the time of our inspection.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Most of the people we spoke with said they felt safe living in the home. However, we found a number of significant safety concerns during our inspection. Staff and the registered manager were not clear what their responsibilities were to safeguard people from abuse. We raised six safeguarding concerns with the local authority during our inspection.

# Summary of findings

Risks to people's safety were not properly assessed, and management plans that were in place were poor. Examples included falls, risk of malnutrition and risk of developing a pressure ulcer. Action was not taken when risks to the property had been identified, including fire and legionella. Where environmental risks had been identified the provider failed to take appropriate action. The provider did not have a suitable schedule in place to ensure that essential maintenance tasks were completed when required. Incidents and accidents were not properly documented or investigated, and appropriate action was not taken to prevent the incident from re-occurring,

People were not kept safe and did not have their needs met because there were not enough staff. The registered manager and provider did not assess the level of people's care needs to determine what staffing levels were appropriate to keep people safe. People said "we need more staff" and "at weekends staffing is bad." While staff tried their hardest they did not have the time they needed to do anything other than meet people's basic care needs. On person said: "carer's are really nice, but they don't have enough time to talk to you".

People's medicines were not safely managed. One person did not get their prescribed medicines for eight days because they were out of stock. People were being given medicines regularly when they had only be prescribed on an as and when basis. Medicines administration records were not always completed so it was not possible to establish if people had received their medicines. Medicines were not always stored securely. On several occasions the medicines cupboard was left unlocked and we found a large number of paracetamol in an unlocked drawer in the manager's office.

Staff were not properly supported with training, supervision and appraisal. Staff had not received training in appropriate subjects such as the Mental Capacity Act (2005) (MCA) and caring for people with dementia. There was no schedule in place for when out of date training would be completed and supervision and appraisals were not up to date. Recruitment practices were not robust and not all of the required information was obtained from staff before they began working for the provider.

Staff were not clear of their responsibilities under the MCA. People's level of capacity had not been appropriately assessed and information about best interest's decisions was not recorded accurately. Not all of the relevant Deprivation of Liberty safeguards (DoLs) applications had been made. Where a DoLs had been granted information about the conditions of the DoLs were not recorded in people's care plans and staff were not aware of what they were. Where a person had Lasting Power of Attorney in place this was not always recorded properly.

People did not have their hydration needs met. People were not offered fluids on a regular basis during the day and did not have access to water or other drinks, except at mealtimes. People's fluid and nutritional intake was not properly monitored. People did not always have access to health care services. Two people had missed hospital appointments because transport was not organised in time, and other appointments were not accurately recorded in the homes appointment diary. People's medical conditions were not well understood by staff and appropriate referrals to health care professionals were not always made.

People told us staff were caring. One person said: "the care is very good. If you ask them (staff) anything they will tell answer you". However we found that people's care needs, choices and preferences were not understood by all staff. People's privacy and dignity were not protected and we observed several occasions where people were not supported with their personal hygiene needs in a dignified manner.

People were not always involved in the assessment and planning of their care needs. People's care plans and records were contradictory and out of date. Staff did not have access to accurate care plans to enable them to meet people's identified needs. Information about changes in people's needs was not communicated between staff and people's needs were not regularly reviewed.

Although the provider had a complaints policy in place, this was not readily available for people and staff to refer to. Complaints were not always recorded or investigated appropriately, and action was not taken to ensure comments or concerns raised were used as an opportunity for learning.

Activities for people using the service were limited. People were not supported to take part in hobbies or other activities that were important to them. All of the

# Summary of findings

people we spoke to said they would like to go on an outing, such as to the shops or for a meal. People were not supported to leave the home and be involved in the community, except when they were attending a medical appointment.

Leadership was not visible from the provider or registered manager. They did not understand their responsibilities and quality monitoring was poor. Many of the issues highlighted at this inspection had not been identified by the registered manager or provider. Records were inaccurate and not always kept securely. Not all of the relevant notifications had been sent to CQC as required by law.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

**Inadequate**

The service was not safe. People were not always protected from avoidable harm or potential abuse because the registered manager and staff did not fully understand their responsibilities.

People's medicines were not managed safely. Some people had not received their medicine because it was out of stock. Medicines were not always stored or disposed of safely.

People's safety was not protected because there were not enough staff to meet their needs. Recruitment practices were not robust. Not all of the relevant checks were carried out before staff began work to ensure people were safe.

Risk assessment and risk managements practices were poor. Individuals did not have the risks to their health and safety properly assessed or managed. Identified risks to the environment had not been rectified.

Incidents and accidents had not been reviewed to ensure risks to people's safety were minimised.

**Is the service effective?**

**Inadequate**

The service was not effective. Staff were not supported with training, supervision and appraisal. People were not protected from the risks associated with receiving care from staff who did not have the knowledge and skills required to carry out their role.

Staff did not have a good understanding of the Mental Capacity Act (2005) or Deprivation of Liberty safeguards (DoLs). Not all of the appropriate DoLs referrals had been made, and when they were the outcome of the DoLs was not recorded.

People were not supported to maintain good health and did not always have access to health care services when they needed it.

People were not properly supported with their hydration needs. People's health was put at risk due to the lack of fluid intake. People had their nutritional needs met, and feedback about the food was positive.

**Is the service caring?**

**Inadequate**

The service was not caring. People's choices and preferences were not well understood and they were not well supported to express their views or make decisions about their care.

People's privacy and dignity was not protected. Although staff were concerned for people's welfare, the provider did not ensure staff were well supported to promote people's privacy and dignity.

**Is the service responsive?**

**Inadequate**

The service was not responsive. People were not supported to be involved in the assessment and planning of their care.

# Summary of findings

People's care needs were not appropriately reviewed and the registered manager and staff were not always clear about individuals care needs because care records and plans were poor.

Complaints were not well managed and the registered manager and provider did not act on feedback from people, relatives or staff.

**Is the service well-led?**

**Inadequate**

The service was not well led. The provider and registered manager did not understand their responsibilities and had not ensured the care provided to people was of high quality.

Quality monitoring processes were poor and had failed to identify any of the concerns found during this inspection.

People were not protected against the risks of unsafe or inappropriate care because accurate and up to date records were not kept.

# Victoria House Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 July and 7 & 14 August 2015 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we looked at and reviewed all the current information we held about the service. This included notifications that we had received. Notifications are events that the provider is required by law to inform us of. We also looked at information we hold about the service including previous reports, safeguarding notifications and investigations, and other information that was shared with us. We spoke with the local authority quality monitoring team and safeguarding team.

A Provider Information Return (PIR) had not been requested as this inspection had been bought forward due to information received. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with 14 people who use the service and two relatives. We spoke with five members of permanent staff, five agency staff, a volunteer, the registered manager and the provider. We reviewed the care records and risk assessments for six people who use the service, the medicines administration records (MAR) for eight people, recruitment records for four staff, and the training and supervision records for all permanent staff currently employed at the service. We reviewed quality monitoring records, policies and other records relating to the management of the service.

Inadequate

# Is the service safe?

## Our findings

Although most people told us they felt safe, we found a number of significant safety concerns during our inspection. Staff and the registered manager had a basic understanding of protecting people from abuse and avoidable harm. They were able to describe how they would recognise the signs of abuse. However, the registered manager was not clear about what his responsibilities were if he thought someone was at risk.

Staff said they would report any concerns to the registered manager but were not sure what they should do if the manager were unavailable. Although the provider had an appropriate safeguarding policy in place, this was not easily accessible for all staff to refer to. It was stored on a computer system which not all staff had access to. We did not see any information around the home to advise staff and others what they should do if they thought someone was at risk.

Two people told us they had possessions which had gone missing and were not found. One person said they hid anything they were worried about and commented: "I hide mine up" when talking about their possessions. During the inspection we had concerns about the safety of a person using the service, and we advised the registered manager he needed to raise an urgent safeguarding alert with the local authority. When we checked to see if this had been done, we were told the registered manager had left a message on an answer phone and did not speak to anyone in person to report what the concerns were. We made a full report to the local authority about this person. After the inspection CQC raised a further five safeguarding alerts with the local authority due to risks to people's safety that had not been identified by the registered manager or any other staff.

People were not protected from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's safety was put at risk because risk assessment and risk management practices at the service were poor. Risk assessments were generic and not centered on each individual. For example, two people had been assessed for their risk of falling. The assessments were identical except for a change of the person's name and medical considerations. In one section the name of a different person appeared in both assessments. Both people had been identified as at medium risk of falling. Both people were observed during the inspection to have very different mobility needs. However, the plan in place to manage the risk to each individual was the same. Other appropriate risk assessments had not been completed. These included risk of developing a pressure ulcer, risk of malnutrition or dehydration and continence care.

The provider was not taking appropriate action when risks to the safety of the premises had been identified. A fire risk assessment had been completed on 10 June 2015 by an external company. The assessment identified 24 high risk hazards. These included missing smoke detectors, fire extinguishers not serviced and fire doors which did not comply with regulations. The registered manager had written an action plan to address these issues and some work had been completed, including installation of smoke detectors and servicing of fire extinguishers. However, when we reviewed the action plan we noted not all of the identified risks were included on the plan. This included fire exit doors that were key locked and insufficient emergency lighting. When we asked people who use the service where they should assemble in the event of a fire they were unsure.

A legionella risk assessment had been completed on 18 March 2015. The home had been assessed as at high risk for legionella bacteria. To reduce the risk to people's safety, the assessor had recommended that most of the required work should be completed within three months. Actions recommended included descaling water outlets and monitoring the temperature of stored hot water. We asked to see evidence of an action plan and recommendations which had been completed, but this could not be provided. The provider was unable to demonstrate that appropriate action had been taken to protect people and others from the risks associated with legionella bacteria.

Some environmental risks had not been identified by the provider. The garden was filled with tree cuttings and branches, chimney stacks and broken furniture. One person told us: "there's a load of rubbish out there" and "it's terrible isn't it?". People's safety may have been at risk if they went into the garden. Two sheds in the garden were unlocked and contained items which may have posed a

# Is the service safe?

hazard. These included paint, broken equipment and crates stored in a disorganised way which may have led to them falling on people if they were moving equipment out of the shed.

The provider did not have an appropriate schedule in place to ensure essential maintenance was kept up to date, for example, fire alarm systems and electrical testing. A lack of routine maintenance places people at risk of injury and can impact on their quality of life. Although staff told us fire equipment and electrical testing had been completed recently, and information attached to the equipment showed this, we were not shown any other records to evidence this. It is important that people have access to safe and well maintained indoor and outdoor areas, and equipment.

People were not kept safe and did not have their needs met because there were not enough staff. When we discussed staffing levels with the registered manager they said; "There are not enough staff" and "I have to be out on the floor all of the time." Most people and staff said there were staff shortages and an over reliance on agency staff to cover shifts. Several people commented on the shortage of staff and said there were too many agency staff. One person said: "We need more staff" and another: "At weekends staffing is bad."

The registered manager and provider did not assess people's care needs to help determine what staffing levels were appropriate to meet people's identified needs and keep them safe. On some shifts there were only two members of staff on duty. Some people require the support of two care workers, for example, to go to the toilet. If both members of staff were supporting one person, there were no other care workers available to help other people if they needed it. Although the service employed a part time house keeper, care workers were also expected to complete cleaning and laundry duties as well as provide care for people.

On several occasions people stopped inspectors to ask for help because there were no care workers available to support them. One person needed help to go to the toilet. We said to the person we would get a member of staff to help them. They replied: "Everyone (staff) says I'll see you in a minute but they never come." While staff tried their hardest to meet people's needs, they did not have enough time to do anything other than meet people' basic care needs. They were rushed and did not have time to engage with people. One person said: "Carers are really nice, but they don't have enough time to talk to you." The provider and registered manager had not assessed the risks to people's safety, and had not taken reasonable action to mitigate the risks to people's safety due to lack of staff.

Incidents and accidents were not properly investigated and action was not taken to reduce the risks to people's safety. For example, one person had a history of frequent falls. No action was taken to investigate a possible cause of the falls or prevent the person from falling again. No referral was made to a health care professional such as the GP or falls clinic to ensure the risk to the person's safety was reduced. The person's care plan had not been reviewed following the repeated falls and there was no evidence on file to show that learning had taken place as a result of these incidents. The registered manager did not assess the risks to people's health and safety, and did not take action to ensure people's safety and reduce the risk of the incident happening again.

People's medicines were not safely managed. Some people were prescribed medicines 'as required' (PRN) by their GP. People took these medicines only if they needed them, for example, if they became anxious. A care plan should be in place to advise staff on how to identify when a person was becoming anxious and what support to give the person. Clear instructions should be given on when and why these medicines should be administered. The PRN medicine had been included in people's daily medicines and were being administered routinely twice a day. No consideration was being given about whether the person needed the medicine or not.

Medicines are sometimes administered to people in a disguised format without the knowledge or consent of the person receiving them. This is sometimes necessary and justified if it is in the person's best interests. One person was receiving covert medicines. The registered manager had not ensured the person's capacity to consent had been considered and the best interest decision was not made in accordance with the Mental Capacity Act 2005 (MCA). A pharmacist had not been consulted to ensure the covert medicines were administered to the person in a safe way.

People did not always receive their medicines as prescribed. One person had not received medicines that were important to manage a health condition for eight days because there were no tablets in stock at the home. Another person required a medicine PRN but this was also

Inadequate

# Is the service safe?

out of stock. Someone else declined to take medicines on occasions, particularly if they did not know the member of staff that was giving it to them. When we reviewed their medicines administration record (MAR) chart we saw the person had declined medicines for three days. Staff were not able to tell us what action had been taken to ensure the person received their medicines as prescribed.

MAR charts were not always completed when people received their medicines. There were gaps in four of the MAR charts we reviewed, with no explanation of why, so it could not be established if the person had received their medicines or not. One person required medicine that was time specific. They did not always get their medicine on time which meant the medicine may not have been effective. Where people were prescribed topical medicines such as creams, records were incomplete. Staff could not demonstrate people's skin conditions had been treated as prescribed. One person did not have a photograph in their MAR charts. It is good practice to include a photograph of the person , so agency staff or new members of staff can be sure they are administering medicines to the right person.

Medicines were not always stored securely. On several occasions we found the medicines room unlocked. On one of these occasions there were medicines left on top of a trolley with no staff present. In the registered managers office we found a large number of soluble paracetamol tablets, paracetamol caplets and one box of laxatives in an unlocked drawer. The boxes had either no prescription label or the label had been torn off. When we showed this to the registered manager he said they should have been disposed of when medicines had been returned but had not been.

Training in medicines administration was poor. Staff completed a training booklet but did not have their competency to administer medicines safely assessed. The registered manager told us they had completed some "on line" training in safe handling of medicines, but not for assessing competency to administer. When we asked how he made sure staff were safe to administer medicines he said: "I take it that they're trained".

People did not have their care and treatment provided in a safe way. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Recruitment practices were not robust. Two of the staff records did not contain information about when a disclosure and barring service (DBS) check had been completed and what the outcome was. A DBS check is completed before staff begin work to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. The registered manager told us these had been completed and no criminal record was found, but did not show us any written evidence to confirm this. None of the records contained a full employment history and three did not contain evidence of the staff member's previous conduct where that employment had involved working in health or social care. It is important for providers to undertake these checks before staff begin work to help ensure that staff employed by the service are safe to work with the people they care for.

The provider had not ensured all staff were thoroughly checked before they started work. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service effective?

## Our findings

People were not protected from the risks of receiving care from staff who were not properly trained. Staff were not well supported with training, supervision and appraisal. Most training was provided in a booklet form which staff had to read and then answer questions. The registered manager told us he had not completed any staff appraisals and only two supervision sessions with staff since November 2014. He also acknowledged that "training is the hardest thing" and "I'm forever chasing staff to complete". The registered manager did not have a policy in place to demonstrate what training they considered mandatory for staff or the frequency that training should be refreshed. Continuous staff development is not only a requirement to meet fundamental standards, it is also a vital element in ensuring that people receive the best care and support.

Of the 16 staff listed in the training records, five had not completed training in safeguarding for more than 2 years, eight for more than one year and three staff had not completed the training at all. The registered manager had not had training in safeguarding since 10 June 2013. None of the staff had training in caring for people with dementia, diabetes or dignity and privacy. People were not receiving effective care based on best practice because staff were not properly trained.

There were no plans in place to address the out of date training. Action had not been taken to ensure staff had the appropriate training particularly in medicines administration, dementia care and the Mental Capacity Act 2005 (MCA) to ensure they could meet the needs of the people they supported. People's safety was at risk because the provider did not ensure staff had the competency and skills to provider care for people safely.

These were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had not received training in the MCA and Deprivation of Liberty Safeguards (DoLs). This legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions for themselves. DoLs aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. Not all of the appropriate DoLs applications had been made to the relevant authority. Two referrals had been made and were granted. However, staff did not know what the conditions of the DoLs were and a copy of the conditions of the DoLs could not be found. There was a risk that people would have their freedom inappropriately restricted.

Staff did not have a good understanding of the principles of the MCA. Care plans did not refer to people's general level of capacity for day to day decisions, and there was minimal evidence of capacity assessments for decisions about specific aspects of people's care in their care plans.

Staff were not clear about what a Lasting Power of Attorney (LPA) was or who had the legal right to make decisions on someone else's behalf. An LPA is a legal tool that allows people to appoint someone to make financial or health and social care decisions on their behalf. If a person had an LPA in place, the registered manager accepted verbal confirmation about this. The LPA was not always viewed or recorded in the person's care plans. The registered manager was unable to clearly demonstrate who had the legal right to make decisions on someone else's behalf. There was a risk that some decisions would be made by next of kin or family members who did not have an appropriate LPA in place.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not well supported with their hydration needs. Older people are at particular risk of dehydration especially those in care homes. People often need support to ensure they get enough to drink. During the inspection we did not observe people being offered drinks except at lunch time. A large jug of squash was available on a table in the lounge but no glasses. However, most people were not able to walk to the where the jug was placed. People were not offered drinks from the jug and we noted the level of fluid had not gone down during the day. Where people were bed fast or sitting in their rooms, jugs of water and glasses were not available. One person had been in bed for most of the day without a drink within in reach. When the person was offered a drink by a relative, they drank a glass and a half very quickly because they were thirsty. We spoke with another person who was also in bed, who asked for a drink several times because they were: "so thirsty".

Inadequate

# Is the service effective?

People did not have their nutrition and hydration needs properly assessed or reviewed. For example, one person needed specific support with their nutritional intake. This was not clearly recorded in the person's care plan, and there was no information for staff in how to support the person appropriately. People's food and fluid intake was not properly monitored or recorded. Proper recording of food and fluid is important because it can help identify if there are changes in people's needs or if a person's health is deteriorating. People's safety was at risk because the provider had not assessed the risks to people's health due to lack of hydration. Action had not been taken to reduce the risks associated with poor fluid intake.

People did not always have access to health care services. One person had missed two hospital appointments because the registered manager had not ensured transport had been arranged. Another person was at risk of having their appointment cancelled because there were not enough staff to escort them to the hospital. When we reviewed the appointments diary we saw appointments for two other people had been incorrectly entered in the diary. Staff were not aware of this and confirmed if we had not pointed this out to them it was likely the people would have missed their appointments.

People were not well supported to maintain good health. People's medical conditions, for example, diabetes and Parkinson's disease were not well understood by staff. Staff were not always aware that people had a particular health condition that needed monitoring closely. Health conditions were not properly monitored so when there was a change to a person's health needs appropriate referrals were not being made. For example, one person had a marked decrease in their appetite. Although this was noted in the person's care plan no action was taken to refer them to an appropriate health care professional, such as the GP or speech and language therapist.

Another person who had been identified as at risk of malnutrition did not have their weight accurately monitored. When significant weight loss was identified an appropriate referral was not made. We spoke with one person who told us they were in pain. When we spoke with staff they said they were aware of this but no action had been taken. We asked staff to call the person's GP and this was done straight away

Although staff completed handovers between shifts these were not effective. Appropriate information about changes in people's health was not always passed on. For example, one person had recently returned from hospital. This information was not handed over between staff and was not documented anywhere for staff to refer to. Staff we spoke with were unaware of the person's stay in hospital. They did not know the person had a very specific care need following their admission to hospital. This put the person's health at significant risk.

Handovers were not recorded so staff did not have anything to refer to, if they needed to check what information had been given to them at the start of their shift. Continuity of information is vital to protect people's safety. Poor handovers between staff can lead to deterioration in people's health because vital information is not passed on. The provider and registered manager had not done everything that was reasonably practicable to reduce the risks to people's health and safety.

People did not have their care and treatment provided in a safe way. These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were, however, some areas of effective nutritional care. People were well supported to have enough to eat and to maintain a balanced diet. Food was homemade and nutritious. People gave us positive feedback about the food. One person described it as: "Very wholesome". A relative said: "The food is absolutely excellent". The menu was planned over four weeks and was varied with a daily choice of food. If a person did not like the choice of food available an alternative was offered. People were offered the appropriate support to eat if they needed, and adapted plates and cutlery were available when required.

Inadequate

# Is the service caring?

## Our findings

Most people told us staff were caring, and their privacy and dignity was protected. One person said: "Care is very good. If you ask them anything they will answer you." When staff spoke with people they were kind, but staff did not have enough time to spend with people to build relationships. One person said: "Carers are really nice but they don't have enough time to talk to you." Staff did not know the people they supported well and had no knowledge of people' personal histories.

Due to the high level of agency staff people's needs, preferences and choice were not well understood. Care plans were inadequate and did not provide staff with the information they needed to meet people's care needs in a consistent way. Care was not centred on the individual and was mainly task led. Although staff were concerned for people's welfare, they were not able to respond to people in a timely way because there weren't enough staff on duty. We asked staff to tell us about people and their knowledge about people's needs was limited. Agency staff had not been given any specific information about peoples individual care needs, likes, dislikes or preferences. For example, one person had a health condition which needed monitoring closely to prevent the person becoming unwell. Two of the agency staff were unaware the person had a health condition so did not know what they should do to support the person if their health condition deteriorated.

People were not well supported to express their views or make decisions about their care. Most of the people we spoke with were not aware they had a care plan in place. Some relatives, where appropriate, supported their family member with making choices and decisions, but most relatives were not given the opportunity to do so. Day to day choices for people were limited. For example, they could not decide when to go to the toilet or what activities they would like to take part in.

People did not receive care that was person centred. These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's dignity and privacy was not protected. Staff were not well supported to promote people's privacy and dignity. The provider did not have a dignity policy in place and staff were not given training in privacy and dignity. We observed several occasions where people were in a state of undress when they were trying to go to the toilet. One person was supported to the toilet which opened onto a corridor. The door was left open and the person was visible to other people in the corridor. On another occasion the registered manager supported a person to clean themselves after using a commode without closing the person's bedroom door. One person said they were told to use their incontinence pad when they needed to go to the toilet because staff did always have time to help them to the lavatory

We saw one person who was in distress in bed. Other people and visitors had a clear view of the person's room and the door was not closed. We went into the person's room and found their incontinence needs had not been met. This had a significant impact on their privacy and dignity. Staff had not noticed the person's distress. We pressed the call bell for help while we re-assured the person. The registered manager came into the room and attended to the person's needs.

We observed two people who did not have clean clothes on and looked untidy. Both people had food stains on their clothes which we pointed out to staff. However, neither person was supported to change into clean clothes during the inspection. People were not well supported to remain as independent as possible. They were not supported to go out, for example, to the shops or for a meal. Most of the people we spoke with said they would like to go on an 'outing'. One person said, "It would be lovely to get out and about."

People did not have their dignity and privacy protected. These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service responsive?

## Our findings

People and those important to them were not supported to be involved in the assessment and planning of their care needs. There was minimal evidence in people's care plans of their views on how they would like to receive their care and support. Preferences and choices were not well recorded, and due to reliance on agency staff, staff were not familiar with this information when it was available.

The service used a computer system and paper records to record people's care plans and assessments. Not all of the staff had access to the computer records. Paper care records were also kept, but these did not always contain the same information as the computer records. Information included in both was sometimes out of date or inaccurate. Where changes had been made to the care people needed, these were not included in the person's care record.

People's care needs were not regularly reviewed and care plans were not updated if they needed to be. For example, one person had been assessed by the district nurse as requiring mouth care to be provided by staff. Although mouth swabs were available in the person's room, there was no written guidance to enable staff to meet the person's oral care and ensure they remained comfortable. Accurate care records are particularly important when agency staff support people who use the service. Agency staff do not always know people well and need accurate and comprehensive care plans available to them so they can meet people's needs in a person centred way.

Daily care records were kept by staff, but these were not fit for purpose. On several occasions, where the daily records showed a person had a change in their health needs, there was no evidence of what action had been taken. Examples included a person complaining of pain, and another person who had a skin tear. There was no mention of this in the person's computer records for that day or any information about what action had been taken by staff. Care workers were recording daily records in several different areas and notes were not always in date order. It was difficult to establish from the daily records what support had been provided for people and when.

A 'communication book' was being used to record information about people's daily care or changes in people's health needs. This information was not always recorded in the individuals care record and information was not communicated between staff appropriately. Examples included two people who had recent admissions to hospital which not all staff were aware of, a person's wound dressings that needed to be monitored and concerns about two people's skin integrity. This meant that people' care needs were not reviewed when they should have been. Care plans could not be updated as required, because appropriate reviews were not being completed.

The registered manager was not fully aware of people's care needs and did not have oversight of people's specific health needs or recent changes to their health. This meant they could not support staff appropriately to ensure vital information about people was shared with all staff working at the service. For example, one person had been identified as at risk from pressure ulcers. The registered manager said a turning chart had been put in place to advise staff on when to support the person to turn in bed. We could not find any evidence of a turning chart and staff we spoke with did not know about the turning chart. Staff have differing opinions of the specific care needs for the person and gave us inconsistent information about what the person's care needs and health conditions were, and what they needed to do to ensure they met the person's needs. Another person had a visit from their GP, but their care plan was not updated to include the advice given by the GP.

People did not receive care that was person centred or met their needs. These were breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the provider had a complaints policy in place, this was not easily available for people who use the service or their representatives. The registered manager was not following the policy or taking the right action to ensure that comments and complaints were dealt with appropriately. The provider did not maintain a complaints log and verbal complaints or comments were not recorded. A complaint that had been made was not thoroughly investigated or responded to in good time. Appropriate action was not taken to address the issues raised and resolve the complaint.

The provider did not use complaints and concerns raised as an opportunity for learning or make changes to the support provided for people if this was appropriate. People and staff's feedback was not always valued by the provider, and people who had raised a concern said they were not always properly dealt with. Although people and relatives

Inadequate

# Is the service responsive?

said they could talk to the manager and he would listen, the registered manager did not take any action. One relative said: "He doesn't take it on board" and another: "the manager's not responsive".

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Activities staff were caring and communicated well with people. However, activities offered to people were limited. We observed people being supported to colour in a poster with felt tip pens, which was being passed around the group of people taking part. Two people said there was a lot of colouring which they did not enjoy, and "not much else". People were encouraged to have a 'sing along' every week. Exercises were done with young people from a local group, but only a small group of people were participating.

Most of the people we spoke with said they would like to have some outings. One resident said, "It would be lovely to get out an about." Another person said they would like to have help to carry on with a hobby that had been particularly important to them. There was minimal evidence that people were supported to take part in activities or hobbies that interested them. People were not supported to with their independence and involvement in the community.

This was a breach of Regulation 10 and of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

Leadership was not visible from the registered manager or provider. The provider did not understand their responsibilities and were unaware the regulations had changed in April 2015. They told us they had employed the registered manager to take responsibility for meeting the fundamental standards and did not understand they shared the responsibility with the registered manager. The provider was not clear in how they supported the service to improve and could not give any appropriate examples of how they had helped the service in the past or any plans they had for the future improvements to the quality of service they provided. Although the registered manager and provider told us they had regular meetings to discuss the service, these were not recorded so they were unable to demonstrate what they had discussed during their meetings. The provider did not complete appropriate quality monitoring so was unaware of the concerns found at this inspection.

People who use the service, their relatives and staff had little involvement in the development of the service. A resident's meeting had not been held for six months and people and relatives could not remember being involved in any questionnaires asking for their opinion of the service or being asked for any other feedback. Although people said they could speak to the manager if they needed anything, relatives and staff said when they raised concerns with the registered manager they were not acted on. One relative said they had raised a concern about their family member. When we asked the relative what action the registered manager had taken they replied: "not a lot".

The registered manager said they had fallen behind on necessary paperwork and managerial tasks because there was "not enough staff" and "I have to be out on the floor all the time". They had discussed this with the provider but no action was taken to ensure enough staff were employed to meet people's needs and allow the registered manager time to meet their legal responsibilities.

The registered manager and provider did not ensure staff were well supported in their role. There was a high level of sickness amongst staff which the registered manager had not taken action to address. Although the registered manager was aware that training, supervision and appraisals for staff were behind, no action had been taken to address this. Regular and good supervision is associated with job satisfaction, commitment to the organisation and staff retention. This in turn can help ensure people receive care from staff who are committed and well-motivated.

The registered manager and provider did not ensure that the delivery of high quality care was integral to the service. Neither of them understood the principles of good quality assurance and why it is important. Quality monitoring procedures were not effective and did not identify areas for improvement. Some quality monitoring audits were completed including health and safety and infection prevention and control. However, these appeared to be a tick box exercise and were not identifying areas for improvement. Although the registered manager told us they completed spot checks to assess the quality of care being provided by staff, these were not recorded so the registered manager could not evidence this.

The registered manager and provider did not have any plans in place for driving improvement. Areas of poor practice can be reduced by means of proactive tools, such as audits. Audits also promote high-quality care and should be carried out regularly. Through regular audits, providers can compare what is actually done against best practice guidelines and policies and procedures. This enables them to put in place actions to improve the performance of individuals and systems.

People were not protected against the risks of unsafe or inappropriate care because accurate and up to date records were not kept. People's care records were not up to date and staff were not clear where they should record information about support they had provided to people. Records containing personal information was hung on noticeboards and not kept securely. Records throughout the home were poor. Documentation was not always dated, signed by staff or fully completed so it was difficult to assess if some documents were up to date or who had completed them. Clear records help to prevent errors. Staff were not aware that everyone involved in looking after people are responsible for keeping good records.

The provider and registered manager did not have good governance systems in place. These were breaches of regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registration requirements were not met. The registered manager did not send us notifications of incidents that had

Inadequate

# Is the service well-led?

occurred as required by law including two occasions when an application for DoLs had been approved. This meant that we did not have the opportunity to assess if the events affecting people who used the service needed CQC to take further action if required.

This was a breach of Regulation 18 (2) Care Quality Commission (Registration) Regulation 2009.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents<br><br>**The provider did not send notifications as required. Regulation 18(2)(c)(e)(f)** |

This section is primarily information for the provider

# Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>Care and treatment was not provided in a safe way for service users. The provider did not assess the risk to the health and safety of service users or take action to mitigate such risks. Medicines were not safely managed. Regulation 12(1)(2)(a)(b)(g). |

**The enforcement action we took:**
Warning notice.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>The provider did not ensure care of service users was appropriate, met their needs or reflect their preferences. The provider did not carry out collaboratively an assessment of needs and preferences for the care and treatment of service users. Regulation 9(1)(a)(b)(c)(3)(a). |

**The enforcement action we took:**
The Care Quality Commission is currently considering the appropriate regulatory response to this breach of the regulations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br><br>The provider did not ensure service users were treated with dignity and respect. Regulation 10(1). |

**The enforcement action we took:**
The Care Quality Commission is currently considering the appropriate regulatory response to this breach of the regulations.

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Enforcement actions

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA (RA) Regulations 2014 Need for consent<br>The provider did not ensure they acted in accordance with the 2005 Act. Regulation 11(3). |

**The enforcement action we took:**
The Care Quality Commission is currently considering the appropriate regulatory response to this breach of the regulations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>The provider did not ensure service users were protected from abuse and improper treatment. Regulation 13(1). |

**The enforcement action we took:**
The Care Quality Commission is currently considering the appropriate regulatory response to this breach of the regulations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints<br>The provider did not investigate complaints or establish an effective system for the handling of complaints. Regulation 16(1)(2). |

**The enforcement action we took:**
The Care Quality Commission is currently considering the appropriate regulatory response to this breach of the regulations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>The provider did not establish or operate effectively a system to ensure they assessed, monitored and improved the quality of service. They did not maintain |

This section is primarily information for the provider

# Enforcement actions

an accurate record for each service user or other such records relating to the management of the regulated activity. They did not act on feedback provided. Regulation 17(1)(2)(a)(c)(d)(ii)(e).

**The enforcement action we took:**
The Care Quality Commission is currently considering the appropriate regulatory response to this breach of the regulations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Persons employed by the service did not receive appropriate training, supervision and appraisal. Regulation 18(2)(a). |

**The enforcement action we took:**
The Care Quality Commission is currently considering the appropriate regulatory response to this breach of the regulations.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>The provider did not ensure all of the information as required by schedule 3 for each person employed was available. Regulation 19(3)(a). |

**The enforcement action we took:**
The Care Quality Commission is currently considering the appropriate regulatory response to this breach of the regulations.